self-report inevitably raises questions about the veracity of the reports, given the secretive nature of individuals with this condition, the absence of case reports in the medical literature is not at all surprising.

Individuals with BIID are not psychotic, being fully aware that other people are likely to consider their desires for amputation to be 'crazy'. Consequently, many individuals who attempt self-amputation try to stage it to look accidental. For example, as reported in the documentary film 'Whole', a middle-aged man became a LAK (left above knee) amputee by shooting his left knee at close range with a shotgun, and then claimed it was the result of a hunting accident. Thus, attempts to self-amputate may have appeared to medical personnel to be accidental rather than intentional and hardly worthy as the subject of a case report. Any doubt that some individuals with BIID become desperate enough to resort to self-amputation is dispelled by the case studies included in the various documentaries and television news programmes (e.g. 'Whole', ABC News Primetime Live, BBC Horizon) that have examined this intriguing but unfortunate condition.

Declaration of Interest

None.

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Research Letter

Mental health systems in Latin American and Caribbean countries: a change in the making

Latin American and Caribbean countries (LAC) are diverse both culturally (e.g. sixteen countries are Spanish-speaking; eight English-speaking; and one each Portuguese-, French- and Dutch-speaking), and economically [fifteen have been classified as low-and-medium-income countries (LMIC), and twelve as high-and-medium-income countries (HMIC)]. In contrast, they are united by a shared past, stained by conquest and exploitation, and by their present struggle to better their populations' wellbeing.

In recent decades, many countries moved from military to democratic regimes. This process was accompanied by socio-cultural movements that included the struggle against human rights' violations of institutionalized psychiatric patients. Indeed, throughout the region mental health care was often delivered by anachronistic custodial institutions, where human conditions were extremely precarious. Today, the mental health policy for the region is based on the Caracas Declaration adopted in 1990 (Levav *et al.* 1994) and reaffirmed more recently by the Brasilia Conference of 2005. Their guiding principles are in common, to protect human rights, to deliver mental health care within the primary health system, to transfer in-patient psychiatric care from mental to general hospitals, and to build up a community network of options of care for people with mental disorders.

However, despite major progress made since 1990, mental health care does not receive the priority it deserves. Indeed, we find worrisome facts in the Mental Health Atlas (WHO, 2005). Some examples of these facts are: (1) In four countries the rate of psychiatrists was higher than 5·0/100 000 inhabitants, while in eighteen countries the rate was less than 2·0/100 000. Moreover, with the exception of Cuba, most of these highly trained professionals practice partially or exclusively in the private sector. (2) Seven countries lacked a mental health policy, five did not have a mental health programme, and six had no legislation. (3) The rate of psychiatric beds was uneven, from a low of 0·34/10 000 in Nicaragua to a high of 10·8/10000 in Grenada. (4) Inequity is present throughout; most of the out-patient units are located in the capital and urban centres, with limited access for the rural population. (5) In eight countries the investment in direct mental health care represented less than 1·0% of the total health budget. Even in HMIC countries, like Argentina,

Brazil and Mexico, the percentage was less than 2·5%. (6) Most of the countries do not provide regular psychiatric training for health professionals, and their level of participation is modest, with the exception of Jamaica where general practitioners and assistant nurses play an important role. (7) National health systems, e.g. Chile and Cuba, offer adequate coverage of mental health care, but in other countries the private sector still plays an important role. (8) Non-governmental organizations are involved but only to a limited extent with mental health care in the region.

There are, however, brighter aspects to this report (WHO, 2005) that are represented by: (1) downsizing of beds in mental hospitals and their increase in general hospitals; (2) custodial care – although still lingering – has started or is accelerating towards abolition; and (3) mental health care – this is slowly becoming an integral component of primary health care, and many individuals with acute episodes of disorders are now being treated in general hospitals. The composite picture that emerges is that mental health care is making progress in some countries although standing still in others, e.g. few community-based services are available, particularly for the young and the elderly, and the capacity to monitor and evaluate services and programmes remains insufficient.

From recent reviews of epidemiological surveys conducted in LAC, and from studies conducted in Chile, Colombia and Mexico we learned about the relative high prevalence rates of psychiatric disorders in the community: the one-year prevalence rate of schizophrenia is around 1·0%, major depression 4·9%, and alcohol dependence 5·7%. Overall, the studies reported a one-year prevalence of psychiatric disorders between 20% and 25%, with a predominance of alcohol abuse/dependence among males, ranging from 4% to 12%. Psychiatric disorders were associated with low levels of income and education, and female gender. Hyman *et al.* (2006) estimated the percentage of the total disease burden for the LAC region for the following major psychiatric disorders: depression 5%, schizophrenia 1%, bipolar disorder 0·9%, and panic disorder 0·2%; neuropsychiatry disorders accounted for 18% of the total. The estimated burden for neuropsychiatry disorders more than doubled from 1990, when it was estimated at 8·8%, showing the impact of the ongoing demographic changes resulting from an increasing ageing population. Those changes in the population pyramid, combined with the existing treatment gap in mental health care (Kohn *et al.* 2005) and the effects of nature and human-made disasters, risk further increasing the burden.

The mental health field, through the Principles adopted at the Conference of Brasilia and the ten Recommendations of the World Health Report 2001 (WHO, 2001) has charted a clear and feasible course of action. However, changes within the mental health system need to come in tandem with those from outside, for example, the meagre budgets allotted thus far ought to become commensurate with the burden of disease. The watchful eyes and the advocacy actions of all mental health stakeholders could make the difference in the mental health scenarios resulting from a dark past, the yet-to-be-fulfilled promises of the present and the expectations of a more promising future.

Declaration of Interest

None.

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